California Medicine

The Medical Practitioner, Alcoholism And Motivation

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■ *Adverse influences on motivation for recovery from alcoholism must be searched for in three areas: society, the medical practitioner and the patient. Society is ambivalent because there is a vicarious release through identification with the cheerful "drunk" coupled with unconscious envy and resentment leading to punitive action.*

The current "alcohol culture" decrees that to drink is to be well, not to drink is to be ill.

The medical profession attempts to suppress, deny, rationalize or reject the problem of alcoholism because it involves a change in attitude and recognition of limitations.

The alcoholic patient has a notorious lack of motivation, but this must be recognized as a symptom of his disease, and with certain techniques this symptom is treatable. Furthermore, motivation fluctuates and many opportunities for treatment are available when the medical practitioner can detect that motivation is high. At times a coercive approach is required, at times a permissive one; and the optimal use of such approaches will increase the motivation to an effective level.

THERE IS MUCH ambivalence in society's attitude toward the alcoholic. For example, drunkenness can be considered as humorous, as a jailable offense or as an extenuating circumstance in such crimes as murder.

The motivations that lead to society's ambivalence appear to be based partly upon a vicarious experience of expansiveness and release of inhibitions through identification with the cheerful drunk, and an often unconscious envy and resentment. When the alcoholic passes the tenuous borderline of "good taste," the good humor may change into overt resentment, and society may institute severe repressive measures. Because of guilt in gratification of "forbidden" impulses through the alcoholic, there is a subsequent need for punitive action against him, and he becomes the scapegoat.

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Many of the contradictory measures in connection with the licensing of establishments for the sale of alcoholic beverages, the use of tax imposts, and the talk, if not action, of control of advertising of alcoholic beverages, are witness to society's fluctuating attitudes. The denial, suppression and confusion of the problem of alcoholism by the community are paralleled by the deliberations of the Food and Drug Administration and other governmental organizations concerning the labeling of cigarettes as a toxic substance. Alcohol has been known for hundreds of years to be toxic, yet not much attention has been given to suggestions (such as Myerson's[23]) that liquor be labeled as a habit-forming, noxious substance.

The Alcohol Culture

Despite praise of alcohol in a recent symposium,[19] and in a recent book,[4] it is not a physiological need of the human organism. It seems a rationalization that the pace of civilization demands the use of alcohol, when there may be evidence that even social drinking may increase mortality. Oddly, the diner who refuses to drink is often looked at askance, whereas an explanation that he is a member of Alcoholics Anonymous is followed by immediate understanding. Apparently to drink is to be well, not to drink is to be ill.[4] When a large majority of adults drink, it is taken for granted that sobriety is abnormality. To avoid such a brand, adults and teenagers may be motivated to drink in spite of other factors influencing them to abstinence.

The Change in Cultural Attitude to Alcohol

It is often said that the prevention of alcoholism, depending as it does on cultural attitudes, is an impossible area to attack. Fortunately, however, this has not been discouraging to everyone and active research is going on in this important field.[10,17] The recognition of the early signs of alcoholism as a significant indication of maladjustment, consistent social disapproval of excessive drinking, and, eventually, the teaching of young children—pre-school and grammar-school age—that alcohol is not a legitimate method of handling emotional problems should considerably ameliorate the problem. Such early training would, of course, require a society-approved consensus regarding "normal" and deviant drinking habits. The more ambivalent the cultural and parental attitudes, the more unpredictable the attitude of the young.

Motivation in the Medical Profession

In our 1956 survey, it was demonstrated that persons addicted to alcohol, although recognized as a legitimate focus of interest by medical practitioners, were generally either rejected or only occasionally accepted for treatment.[11] When treatment was attempted, the results were notoriously poor. Therefore, leadership in the fields of prevention and treatment of alcoholism has fallen to social workers, psychologists, educators, Alcoholics Anonymous, and, more recently, public health officers.

Rationalizations of Physicians

The caring professions, however, just as society as a whole, have attempted to suppress, deny, rationalize or ignore the problem. Alcoholics, they say, for example, are incurable, or they represent a moral problem, not one of disease, or they don't want to get well, or there is no time to treat them adequately. Only the most intrepid souls seem willing to accept the challenge of alcoholism and often the accompanying opprobrium and downgrading. Perhaps those who have less need to be omnipotent and to cure all their patients, or less need to have dutiful patients, or even those who have, in a reverse way, masochistic needs, will treat alcoholics. In any event, defective techniques, inadequate case finding and incomplete medical histories noted in a recent study indicate the discomfort of the medical practitioner and his disinclination to treat alcoholics.[16]

The Antidote

The cure for such rationalizations has become apparent. It includes increased motivation, information, education and training. Supervision of medical practitioners' treatment of alcoholics reveals that problems of motivation often supersede deficiencies in knowledge and technique. Attitudes of hopelessness toward alcoholics lead to attitudes of helplessness. When the motivations of alcoholics are understood and accepted, physicians can overcome a disinclination to treat them.

Motivation in the Patient

In dealing with an alcoholic, we are almost invariably faced with poor motivation for change. Lack of motivation is so important and is so in-

trinsic to the disorder that it can be considered an integral symptom of the problem drinker. The influence that this lack of motivation has on the attitude of the medical practitioner is well exemplified in a recent survey of state hospital attitudes.[21] Seventy-three per cent of the hospitals reporting indicated that the poor results they reported were due to the poor motivation of the patient.

Types of Motivation

Anyone dealing with an alcoholic must learn to stimulate the patient's interest in making a change. In this connection, as an analogy, we can look at the two principal methods of pedagogy: the aggressive, forceful and punitive (such as jailing or withdrawal of moral support); and its opposite, the permissive, noncensorious, affectionate and approving, which connotes, essentially, the giving of love and support.[6,7] Both of these general methods can be used—singly, alternately or simultaneously in various admixtures. The situation may demand permissiveness in one area and coercion in another, and the medical practitioner can become quite comfortable with apparently inconsistent attitudes.

We must consider the motivation of the alcoholic for therapy in general and for psychotherapy specifically. The alcoholic is willing to accept hospitalization and drugs in the acute phase. When he is physically and emotionally depleted from his binge or is in a coma, he has no resistance to physical treatment. At such a time he has an immediate need to quell the disturbed and painful physiological sensations, especially during the withdrawal stage. He is well motivated for the physical treatment of the medical practitioner, in which he is a passive participant, but is usually less accessible to psychological treatment, which makes considerable demands upon him. This tendency is even more pronounced in the lower socioeconomic groups,[15] although with alcoholics it is also strong in the higher socioeconomic groups, because of such defense mechanisms as denial or suppression of the problem.

The Basis of Motivation

What can treatment give to the alcoholic, and what does it take away from him? In the interval between acute withdrawal episodes, deprivation of alcohol is taking from the alcoholic all that makes life worth living. What can he be offered that is as good? This is something that is frequently difficult to find. Many an alcoholic would find life arduous and unrewarding even without the handicap of alcoholism. Ordinarily, telling the patient that life is good is useless. He has tried to convince himself of this, and many others have undoubtedly told him so for many years. Demonstrating that life is worthwhile does have value, particularly through organizations such as Alcoholics Anonymous, where the patient may participate passively for many weeks, observing that others in a similar situation have begun to regard life as worthwhile.

Most important, of course, is the *experience* that life can be rewarding. Attaining this experience depends primarily on what factors in life the patient considers particularly important, and what he feels the opportunities are for obtaining gratification. These factors are often unconscious, and therefore not accessible to the patient. They may remain unconscious, yet be gratified, as they often are, in the experiences that come with the acceptance of and the carrying out of the principles of Alcoholics Anonymous. The most valuable method of demonstration in the area of medical practice lies in the process of psychotherapy. In such a situation, in a mutual participation and through recognition of misinterpreted experiences, there can be an alteration in attitudes that induces the alcoholic to try again, and, perhaps this time, to recognize and savor some of the "better things in life." It is the patient himself who interprets what these better things are, and when he reaches this point he will be motivated.

Fluctuations in Motivation

There are many different sources of the motivation that leads an alcoholic to treatment. The recognition that he is ill may fluctuate, coming only at certain times and under certain circumstances and stresses, but advantage should be taken of this reality-orientation, episodic and uncertain as it may be, even if such motivation may actually depend upon secondary gains. For example, it may serve to take pressure off the patient, who can then say, perhaps to a no-longer-tolerant employer or spouse, "You see, I am trying my best to cure myself."

On the other hand, motivation may be diminished by an inadequate external environment from which the patient sees no possibility of escaping, such as an aggressive and domineering mother who

nevertheless cares for and supports him, so that he feels he cannot change his milieu. Or he may have a crippling physical illness which cannot be cured, or some unsightly personal characteristic. Also, much alcoholism is in lower socioeconomic groups where the alcoholic is often of deteriorated or subnormal mentality and would have, at best, little to look forward to. Improvement in social and economic conditions and greater opportunities in life could give many alcoholics the incentive to change their mode of life.

During psychotherapy, motivation may be increased temporarily when the patient ascribes omnipotence to the therapist and has the expectation of magical help. While such illusions may be helpful in the early phase of treatment, this motivation may be quickly dissipated as soon as the patient recognizes reality or becomes disillusioned in the projected powers of the therapist. Alternations in fantasies of the patient may produce alternations in attitudes toward treatment. If the therapist appears as an agent of society, there is often considerable rebellion and hostility, possibly leading to termination of treatment. As long as the patient receives transference gratifications of an infantile nature from the therapist, treatment may progress, and such gratification can be knowingly and systematically given. The patient, through intuitive perception, however, may recognize an unconscious hostile countertransference on the part of the therapist; and, should this occur, there is a rapid decrease in motivation and dissolution of treatment. The very realization by the patient that, to succeed, he must undergo a certain amount of suffering may decrease motivation to the point where therapy is sacrificed.[24]

It should be reemphasized that lack of motivation may be temporary—since this factor does waver and fluctuate—and therefore should not be considered a bar to successful aid. While the alcoholic's defenses are formidable, they are not impregnable.

Physicians' Misconceptions of Motivation

Patients with apparently good motivation are more likely to be selected for treatment by medical practitioners and to be helped by psychotherapy.[2] Patients with a psychoneurotic label who are cooperative are more likely to receive help than the sociopath who acts out his impulses and feelings, or the alcoholic who reacts with self-destructive patterns. Yet observation indicates that, even if the alcoholic is accepted for treatment, there is often so great a countertransference from the therapist that adequate therapy is impossible. A study from the Alcoholism Research Clinic indicates that the patient's compliance with the requirements of psychotherapy, such as attendance, responsiveness and verbalization, was often adopted by the therapist as the chief criterion of motivation for cure.[9] The method may have to be adapted to the case, and rigid attitudes toward the patient's apparent noncooperation may have to be replaced by more permissive ones. Another study has shown that where both motivation in the patient and empathy in the therapist are high, therapy is short and successful. When both are low, therapy is short but unsuccessful. When the therapist's empathy is high but the patient's motivation is low, therapy is long and unsuccessful. Further, experienced therapists tend to view patients as more like themselves, thus reducing psychological distance, whereas inexperienced therapists do the reverse.[3]

Inducing Motivation

It is often stated that nothing can be done for the alcoholic until he "hits bottom," at which point his precarious state induces adequate motivation. This is especially emphasized by Alcoholics Anonymous. The phrase "hitting bottom" is understood to mean that the alcoholic has reached his lowest point in deterioration or degradation. He may remain at this point indefinitely, or he may start a slow and tortuous climb. This bottom varies with the individual; it may be at the point of blackouts and physical symptoms, loss of a job, loss of family and friends, or loss of faith in his own abilities. He may even descend to the skid-row level. The medical practitioner, however, through training and tradition, feels obligated to treat the patient at the level at which he presents himself in the office, whether or not he has yet hit bottom. Accordingly, it is especially necessary to be able to inspire motivation in the patient even at this earlier stage.

Management of Motivation

Inducing motivation is not always easy, but certain procedures can be useful. For example, the removal of secondary gains may help the patient hit his own particular bottom. Often a wife or mother sympathizes too intensely with the alcoholic, makes excuses for him, calls his employer with the plea of sickness and takes many of the

ordinary responsibilities of living from his shoulders. If the medical practitioner can manage to have these secondary gains withdrawn, it may impel the alcoholic to seek help.[12] The practitioner can also create or precipitate the motivating crisis in other ways. If the patient prizes a special attribute or ability, such as intelligence, it may be possible to precipitate him into treatment by demonstrating an impairment, using psychological tests. In the case of one patient who particularly emphasized his bodily integrity, evidence of liver disorder was the key to motivation for therapy. In another case, it was fear of insanity. Or the danger of losing cherished children may lead to "surrender" and eventual change, as may delirium tremens, or the decision of a wife to leave her alcoholic husband. For example:

The husband of a patient was an alcoholic, but did not acknowledge it. As the wife progressed in therapy she gave up her masochistic attitude toward her husband, attended several Alanon meetings and withdrew her neurotic support of the "alcoholic equilibrium." Shortly thereafter the husband began to read articles on alcoholism. Finally he took one of the tests appearing in a current magazine and decided that he was, indeed, an alcoholic. He joined Alcoholics Anonymous and is still an active member after five years.

Motivation by coercion is thus also important. We can include in this category any reward or punishment important enough to cause the alcoholic to forego the pleasure and needs of drinking, such as the threat of jail, of loss of financial support, or of a job.[18] In the survey mentioned previously, 60 per cent of psychiatrists queried felt that legal commitment of alcoholics to state hospitals was beneficial to treatment. Recovery and improvement rates in industrial clinics where there is considerable coercion are much higher than elsewhere, since the alcoholic is still in a state where his job is of considerable and perhaps overriding importance to him. Few, if any, alcoholics decide to stop drinking until some pressure is put on them,[18] and protecting the patient from the consequences of alcoholism can only postpone treatment and reduce its effectiveness.

The Physician's Role

At various times the alcoholic may look upon the medical practitioner as a guide, friend, protector or teacher. He may need the practitioner to intervene between his parents and himself or his wife and himself, or to help with some legal, social or financial problem. The practitioner must have the capacity to understand these needs either by intuitive perception or by the more arduous method of careful history-taking and discussion. When he is alert to these needs, he can fill the role the patient assigns him, thereby relieving anxiety and increasing motivation. The physician must decide whether to accede to such needs or not, depending on the situation at the moment.

Whether or not the fact is consciously recognized, persons who have the most severe type of alcoholism have lost much of the meaning of social interaction and have given up the social mores of the group. Idealism has become ridiculous to them, cultural mores have come to be regarded with destructive cynicism, and problems of life have been met with concealed resentment and outward passivity. Reward and punishment no longer influence them and finally apathy supervenes.[1] Many alcoholics are able to renew previous attitudes toward prevailing mores, but it should be accepted by the physician that many no longer have the capacity to compete in their original milieu and must therefore accept a different job, a different socioeconomic status and different activities from those of their earlier years.

The medical practitioner must also consider removing the alcoholic from his current environment. A vicious circle of drinking, quarreling and further retaliatory drinking may have been established which can be broken only by a temporary removal of the more overtly disruptive member. This is often made easier by a willingness on the part of the alcoholic to trust himself to strangers rather than to a spouse or sober relatives or friends This can be at least a temporary advantage, can increase motivation and can provide a rationale for hospital care, a foster home or a half-way house.

The physician should be particularly aware of the defense mechanism of denial.[13,22] Its intensity makes it possible for the alcoholic to deny not only the desire for drinking, but also the intense effects, such as anxiety and depression. Frequently when writers speak of anxiety, guilt and depression, they are speaking not of an overt and conscious effect but of an unconscious one. Most often the alcoholic who is sober does not consciously perceive these, although he may claim to. It is only at certain critical times, when a particularly sensitive area is touched, such as

noted above—when a period of depression supervenes, a bad hangover occurs or a confrontation is made which the patient cannot escape—that the denial mechanism breaks down. At these times the alcoholic becomes most accessible to intervention, and such opportunities should be awaited and utilized.

The Use of Coercion in Motivation

Other observers have emphasized the need to reinforce abstinence. In one study it was noted that, to the alcoholic, the need for disulfiram or for psychotherapy decreases as the time since the last drinking bout increases. From this observation it was suggested that, for sustained abstinence, pain must be continuously linked with drinking, since the aversive response becomes extinguished. A treatment program, therefore, must provide some method to reinforce the need for abstinence. An important development in the past decade has been the court referral of alcoholics to various helping or treatment modalities. The alcoholics who do best under this coercion have adequate ego strength, higher levels of anxiety and shame, greater response to authority and conscience and more willingness to accept help.[20] Davis and Ditman of the Alcoholism Research Clinic found that over a 15-week period clinic attendance by court-referred patients could equal that of self-referred patients. They concluded that alcoholic outpatients may be as motivated for treatment as nonalcoholic psychiatric patients.[8]

Many workers emphasize a liaison between probation officers and the medical practitioner to aid in maintaining a continuation of therapy. It is of considerable interest that an alcoholic will accept the authority of the judge and faithfully attend the alcoholism clinic or Alcoholics Anonymous when, in actuality, he usually has no abhorrence of jail sentence. Frequently enough such a patient has been jailed many times before. I believe this willingness to obey a court order is due primarily to a projection of paternal or maternal omnipotence onto the figure on the bench and not to the actual temporal power of this authority.

Other nations have attacked the problem of motivation in a similar way. In Czechoslovakia an arrest for drunkenness obliges the individual to attend six lectures on alcoholism.[5] If the person is a chronic alcoholic or has a second arrest, he is required to take protracted psychotherapy and disulfiram. If he fails again, he is put into an institution for three months. It is reported that the alcoholism rate has fallen in Czechoslovakia.

Information and Education

The influence of information and education on motivation in the patient is as yet uncertain and too unreliable for the physician to depend upon. It is only an impression that the education carried on by the National Council on Alcoholism and other antialcoholism agencies has helped, but it has not been determined whether this information and education has produced the results intended. This point has been highlighted by the recent activity with regard to smoking. An appraisal a year after the report of the Surgeon General on the adverse effects of smoking indicated that smoking decreased at first, but later reurned to the old levels.[25] It is obvious, therefore, that "scare techniques" or reliance on the individual's doing what is best for him are not adequate methods.

Cigarette advertising has been criticized but no facts have been brought forward to attest the adverse effect of such advertising. In some of our own work on this subject, we found that when drinking, alcoholics responded to the pictures of liquor in liquor advertising, but that dry alcoholics, when asked to describe the advertisements, omitted mention of the prominently displayed liquor.[14] We considered this due to unconscious denial. Denial requires energy to maintain the purposive exclusion of fact, and therefore impoverishes the ego. The maintenance of abstinence by denial is a difficult task, which may help explain the persistent personality problems in abstinent alcoholics and members of Alcoholics Anonymous.

Conclusion

An understanding of motivation will enable the physician to comprehend ambivalences in society, in himself and in alcoholics and to reach that state of objectivity which is the most important factor in the treatment of the alcoholic patient.

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